STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING _____ B. WING _____	R-C 10/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	**2350 TAFT ST GARY, IN 46404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit to the Investigation of Complaints IN00137120 and IN00137473 investigated on October 8, 2013. This visit was in conjunction with the Investigation of Complaints IN00136117, IN00137107, IN00137922, and IN00138560. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00128277 and IN00129429 completed on July 26, 2013. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00134339 and IN00134814 completed on August 23, 2013. Complaint IN00137120-Corrected Complaint IN00137473-Corrected Survey dates: October 23, 24, 25, 28, & 29, 2013 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Survey team: Janet Adams, RN, TC Heather Hite, RN October 28, 2013 Census bed type: SNF: 6 SNF/NF: 116	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING _____ B. WING _____	R-C 10/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	**2350 TAFT ST GARY, IN 46404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Total: 122 Census payor type: Medicare: 17 Medicaid: 100 Other: 5 Total: 122 Sample: 25 Timberview Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to the Investigation of Complaints IN00137120 and IN00137473. Quality review completed on October 31, 2013, by Janelyn Kulik, RN.	{F 000}		